

NOV 12 1940

Registration District No. _____

Primary Registration District No. _____

1002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Kansas City Conv. Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 yr. 10 mo.
In this community Unknown
years, months or days

3. (a) PRINT FULL NAME Joseph Hughes

3. (b) If veteran, name war Unk 3. (c) Social Security No. unk

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced —

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive — years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years 75 Months — Days — If less than one day hr. min.

9. Birthplace Unknown (City, town or county) (State or foreign country)

10. Usual occupation Unknown

11. Industry or business Unknown

12. Name Unknown

13. Birthplace Unknown (City, town or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown (City, town or county) (State or foreign country)

16. (a) Informant Records
(b) Address KG Conv. Home

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5 - 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Paul Walter
(b) Address 7406 Wornall Rd.
19. (a) 10-4-40 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 514 1/2 Main
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 29th
year 1940 hour 4:30 minute a M.

21. I hereby certify that I attended the deceased from June 22
1940, to Sept 28 1940

that I last saw him alive on Sept 28 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis

Due to Alumina

Due to Chronic hepatitis

Other conditions (Include pregnancy within 3 months of death) 131

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury 1

23. Signature A. P. Lauerman (M. D. or other) 10/2/40
Address 428 S. White Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Harley Roe, Registered Apprentice No. _____,
working under my personal supervision.

Signed *Harley Roe*

Licensed Embalmer No. *2810*

P. O. Address *140 2nd*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.